

# Lung Diagnostic Assessment Program Referral Form

Please note:

- For an inpatient or urgent consult, please contact the respirologist on call at Grand River Hospital (519-749-4300).
- A CT chest is **required** for the specialist consult.
- Biopsies are **not** done on the first visit.

**Referral Date:**

\_\_\_\_\_  
YYYY MM DD

## Patient Information (please print)

## Referring Physician Information (please print)

Health Card Number:	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other:	Name:
VC:	Restricted Mobility: <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone:
Last Name:	First Name:	Fax:
DOB: _____ YYYY MM DD	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Street Address:
Street Address:	City/Town:	City/Town:
Province:	Postal Code:	Email:
Phone (home):	Patient consents to leave message: <input type="checkbox"/> Yes <input type="checkbox"/> No	Billing Number:
Phone (cell):	Patient consents to leave message: <input type="checkbox"/> Yes <input type="checkbox"/> No	Signature:
Email:	Patient consents to receive information by email: <input type="checkbox"/> Yes <input type="checkbox"/> No	

## Medical History

A CT chest is **required** for the specialist consult.

Abnormal CT chest: Date of suspicious CT \_\_\_\_\_ (include CT report)  
YYYY MM DD

Abnormal chest x-ray: Date of suspicious x-ray \_\_\_\_\_ (include x-ray report)  
YYYY MM DD

Indicate all that apply:

- Blood work included with creatinine  
 Allergic to contrast  Diabetic  Taking Metformin  On blood thinner

## Clinical Information

Brief history, updated medication list, PFTs and blood work, if available:

### Previous Tests and Consultations:

Test	Date	Location

Has the patient had a previous visit with a respirologist?  Yes  No

Name: \_\_\_\_\_

**Please send completed referral and all related reports to:**

**Fax: (519) 749-4384**  
**Phone: (519) 749-4300 ext. 5458**